



STATEMENT OF FACTS FOR CASH AID, FOOD STAMPS, AND MEDI-CAL/ STATE-RUN COUNTY MEDICAL SERVICES PROGRAM (CMSP)

- Fill in the answers to all questions about the benefit(s) you are asking for. Print all answers in ink. The "CA" for Cash Aid, "FS" for Food Stamps, and "MC" for Medi-Cal/State CMSP listed to the left of each question tell you which questions are for each program.
- Give any proof (such as bills, receipts and records) to support your answers. Tell your worker when you need help in getting proof or in filling out this form. If you need more space, attach another sheet.
- If you are asking for Food Stamps and you are not an adult member of the household, attach a written authorization signed by the head of household or other adult member.

CA FS MC ① A. Person applying, or caretaker relative of child(ren) for whom aid is wanted. NAME: _____			HOME PHONE () _____		
HOME ADDRESS (NUMBER, STREET) _____			MAILING ADDRESS (IF DIFFERENT) _____		
CITY _____ STATE _____ ZIP CODE _____			CITY _____ STATE _____ ZIP CODE _____		
			DAYTIME PHONE () _____		

FS B. Are you homeless? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "YES": Are you temporarily staying in someone else's home? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES": Give date you began staying at this home: _____
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② For each ADULT living in the home, give us all the facts.

CA (A) ADULT'S NAME (FIRST, MIDDLE, LAST) _____ FS MC			CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____			BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____		
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY		
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP			MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed		

CA (B) ADULT'S NAME (FIRST, MIDDLE, LAST) _____ FS MC			CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____			BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____		
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY		
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP			MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed		

CA (C) ADULT'S NAME (FIRST, MIDDLE, LAST) _____ FS MC			CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. Citizen/National <input type="checkbox"/> Noncitizen: Sponsored <input type="checkbox"/> YES <input type="checkbox"/> NO		
RELATIONSHIP TO APPLICANT OR CARETAKER RELATIVE TO CHILD(REN) _____			BIRTHDATE (MONTH DAY YEAR) _____ SOCIAL SECURITY NUMBER _____		
SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BLIND, DEAF OR DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHPLACE CITY STATE COUNTRY		
TYPE OF AID REQUESTED (✓) <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> None <input type="checkbox"/> Medi-Cal <input type="checkbox"/> State CMSP			MARITAL STATUS (✓) <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common Law <input type="checkbox"/> Widowed		

COUNTY USE ONLY

FS NON-HH/EXCLUDED MEMBER (63-402)	FS WORK/TRAINING EXEMPTIONS (63-407.21)	FS ABAWD EXEMPTIONS (63-410.3)
1. Separate HH (Purchase/prepare) (.12, .13)	a. Under 16/60 or older	1. ABAWD with FS Work/Training Exemption Code 63-407.21
2. Separate HH (Elderly/disabled) (.17)	a.(1) 16/17 not head of household; or	2. Under 18/50 or older (.321)
3. Roomer (must be listed in 13) (.211)	16/17 in school/training at least	3. Pregnant (.322)
4. Live-in attendant (.212)	1/2 time	4. Adult living in HH with dep. child (.323)
5. Other shared living quarters (.213)	b. Mentally/physically unfit for work	5. Lives in ABAWD exempt area (.33)
6. Ineligible alien (.221)	c. Mandatory participant in Welfare to Work activities	
7. Boarder (must be listed in 13) (.3)	d. Cares for child under 6 or incapacitated person	
8. SSN disqualified (.222)	e. Applicant for/recipient of UIB	
9. IPV disqualified (.223)	f. Participant in drug/alcohol program	
10. Workfare sanctioned (.225)	g. 30 hour week/min. x 30	
11. SSI/SSP recipient (.226)	h. 1/2 time student in school, training or higher education.	
12. Ineligible student (.227)		
13. Work req. disqualified (.228)		
14. Questionable Citizenship (300.51(b))		
15. Vol. quit ineligible (408.1, .2)		
16. Ineligible/disqualified ABAWD (410.4)		
17. Fleeing felon/parole or probation violator (.224)		
18. Drug felon (.229)		

COUNTY USE ONLY

CASE NAME _____		
CASE NUMBER _____		
WORKER _____	DATE RCD _____	
<input type="checkbox"/> New <input type="checkbox"/> Restoration <input type="checkbox"/> Redetermine <input type="checkbox"/> Recertification <input type="checkbox"/> Residency Verified <input type="checkbox"/> FS ID <input type="checkbox"/> FS Aged/Disabled Verified <input type="checkbox"/> MC ID <input type="checkbox"/> MC Minor Consent: Exempt from ID, Residency, SSN, Verifs		

<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code: _____ Work Registration/Exemption Codes: WELFARE to WORK FS ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg. # _____ D.O.E. _____

<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code: _____ Work Registration/Exemption Codes: WELFARE to WORK FS ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg. # _____ D.O.E. _____

<input type="checkbox"/> AU <input type="checkbox"/> NON-AU <input type="checkbox"/> MFBU FS Non-HH/Excluded Member Code: _____ Work Registration/Exemption Codes: WELFARE to WORK FS ABAWD
VERIFIED: <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> SSN <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE Alien Reg. # _____ D.O.E. _____

W/W WORK EXEMPTIONS (42-712)
Age under 16 (.41)
School Attendance (.42)
Age 60 or older (.43)
Disability (.44)
NCR caring for dependent or ward of the court or at risk of FC placement (.45)
Care of another ill or incap member of the household (.46)
Care of child:
- Age 6 months or under (or as allowed under county's CalWORKs plan) (.471)
- Member (who previously claimed .471) upon birth or adoption of subsequent child(ren) (.472)
Pregnancy (.48)
VISTA-full or part time volunteer (.49)

CA FS MC (A) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEATH DISABILITY ABSENCE UNEMPLOYMENT	CW 2.1 CW 371 Alien Reg. # D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:		Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME			
CA FS MC (B) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEATH DISABILITY ABSENCE UNEMPLOYMENT	CW 2.1 CW 371 Alien Reg. # D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:		Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME			
CA FS MC (C) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEATH DISABILITY ABSENCE UNEMPLOYMENT	CW 2.1 CW 371 Alien Reg. # D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:		Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME			
CA FS MC (D) CHILD'S NAME (FIRST, MIDDLE, LAST)		CITIZEN/NONCITIZEN STATUS (✓) <input type="checkbox"/> U.S. CITIZEN/NATIONAL <input type="checkbox"/> NONCITIZEN: SPONSORED <input type="checkbox"/> YES <input type="checkbox"/> NO		CHILD NEEDS AID BECAUSE OF PARENT'S (CHECK (✓) BELOW)		AU (✓) <input type="checkbox"/> NON-AU (✓) <input type="checkbox"/> MFBU (✓) <input type="checkbox"/> MFG CHILD <input type="checkbox"/> FS Non-HH/Excluded Member Code:	
SOCIAL SECURITY NUMBER		SEX (✓) <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE OR DUE DATE (Month, Day, Year)	AGE OF CHILD		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> MC: not in home, 18-21 & tax dep.	
BIRTHPLACE (CITY/STATE/COUNTRY)		PREGNANT <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE IMMUNIZATIONS UP TO DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO	BLIND, DEAF OR DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DEATH DISABILITY ABSENCE UNEMPLOYMENT	CW 2.1 CW 371 Alien Reg. # D.O.E.	
IS THIS CHILD CURRENTLY ENROLLED IN SCHOOL? (✓) <input type="checkbox"/> YES <input type="checkbox"/> NO		Work Registration/Exemption Codes:					
IF YES, NAME OF SCHOOL:		Welfare-to-Work FS					
TYPE OF AID REQUESTED <input type="checkbox"/> Cash Aid <input type="checkbox"/> Food Stamps <input type="checkbox"/> Medi-Cal <input type="checkbox"/> None		MOTHER'S NAME				Verified: <input type="checkbox"/> Age <input type="checkbox"/> Deprivation <input type="checkbox"/> SSN <input type="checkbox"/> Blind/Deaf/Disabled <input type="checkbox"/> DED Packet <input type="checkbox"/> Citizen <input type="checkbox"/> Eligible Noncitizen <input type="checkbox"/> SAVE <input type="checkbox"/> Immunization <input type="checkbox"/> School Attendance	
RELATIONSHIP TO APPLICANT OR TO THE CHILD'S CARETAKER RELATIVE		IS CHILD LIVING IN YOUR HOME NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S NAME			

CA ④ List any parent(s) of the child(ren) or unborn who does not live in the home with you.				COUNTY USE ONLY	
NAME OF PARENT		REASON THE PARENT DOES NOT LIVE IN THE HOME		<input type="checkbox"/> Verif. on File <input type="checkbox"/> MC 13	
CA FS ⑤ Has anyone changed citizenship/immigration status in the last 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", complete below:					
NAME		WHAT CHANGED	DATE	ALIEN NUMBER (IF APPLICABLE)	
CA FS ⑥ A. Is a foster child living in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> CA and FC Elig/CR Chooses: Child: <input type="checkbox"/> CA <input type="checkbox"/> FC CR: <input type="checkbox"/> CA <input type="checkbox"/> None <input type="checkbox"/> Kin-GAP	
If "YES", who:					
FS B. Do you want the foster child(ren) and foster care income counted on the Food Stamp Case? <input type="checkbox"/> YES <input type="checkbox"/> NO					
CA FS ⑦ Has anyone ever used any other name (maiden, adoptive, etc.)? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", complete below:					
NAME		OTHER NAME(S) USED			
NAME		OTHER NAME(S) USED			
			YES	NO	
CA MC ⑧ A. Does everyone live in California?					Calif. Resident: <input type="checkbox"/> YES <input type="checkbox"/> NO
If "NO", explain:					
CA B. Does everyone plan to stay in California permanently?					<input type="checkbox"/> Property
CA C. Does anyone own, lease or maintain a home outside California?					<input type="checkbox"/> PA
CA MC D. Is anyone currently getting public assistance outside California?					
If "YES", explain:					
CA E. Is anyone planning to leave California for more than 30 days?					
MC ⑨ Are you 18 to 21 years of age and claimed as a dependent for income tax purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> Tax Dependent Letter Sent <input type="checkbox"/> CA 2.1	
If Yes, who:					
CA FS ⑩ A. Has anyone's cash aid or food stamps been stopped due to: non-cooperation during a quality control review, work or training sanctions or failure to meet the Food Stamp Able Bodied Adults Without Dependent (ABAWD) work requirement, or for any other reason? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", explain below:					
NAME		WHY	WHEN	WHAT COUNTY/STATE	
CA FS B. Has anyone's cash aid or food stamps been stopped for a period of time or forever due to welfare fraud or a food stamp Intentional Program Violation? <input type="checkbox"/> YES <input type="checkbox"/> NO					
If "YES", explain below:					
NAME		WHY	WHEN	WHAT COUNTY/STATE	
FS ⑪ Does anyone living with you buy food and fix meals separately from others in the home? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", who:					
FS ⑫ Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? <input type="checkbox"/> YES <input type="checkbox"/> NO				Separate household eligible: <input type="checkbox"/> YES <input type="checkbox"/> NO	
If "YES", who:					

FS 13 A. Do you pay someone else for meals and/or a room? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						COUNTY USE ONLY					
NAME OF PERSON YOU PAY		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY			
CA FS B. Does anyone pay you for meals and/or a room?											
NAME OF PERSON WHO PAYS YOU		CHECK (✓) <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Both		HOW MUCH \$		HOW OFTEN		NO. OF MEALS PER DAY			
FS 14 Does anyone get food from any of the following programs? <input type="checkbox"/> YES <input type="checkbox"/> NO • Communal dining facility for the elderly or disabled • Food distribution program operated by a Native American reservation • Other food program											
NAME		NAME OF PROGRAM		NAME		NAME OF PROGRAM					
CA FS MC 15 A. Does anyone live in any of the following: <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below: <div style="display: flex; justify-content: space-between;"> <div> <ul style="list-style-type: none"> • Shelter, center • Reservation for Native Americans • Psychiatric hospital/mental institution • Group living arrangement for the disabled/blind </div> <div> <ul style="list-style-type: none"> • Hospital or nursing home • Subsidized housing for the elderly • Drug or alcohol rehabilitation center • Board and care home • Penal institution/correctional facility </div> </div>						FS Eligible Institution:		<input type="checkbox"/> YES <input type="checkbox"/> NO			
						CA Eligible:		<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		NAME OF CENTER, SHELTER, HOSPITAL, ETC.		DATE ENTERED		DATE EXPECTED TO LEAVE					
MC B. Does the person who is in a hospital or nursing home have a spouse or other family member at home? <input type="checkbox"/> YES <input type="checkbox"/> NO											
CA 16 List any child age 6-16 who does not attend school regularly and explain why he/she is not attending regularly. <input type="checkbox"/> No Child Age 6-16						School Attendance Verified:		<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		REASON NOT ATTENDING SCHOOL REGULARLY									
CA FS MC 17 A. Is anyone age 14 or older enrolled in school, college, or a training program? If "YES", complete below: <input type="checkbox"/> YES <input type="checkbox"/> NO						School Enrollment Verif.:		<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM		ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):		UNITS/HOURS PER WEEK		WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO		
							EXPECTED DATE OF GRADUATION				
NAME		AGE	NAME OF SCHOOL/COLLEGE/TRAINING PROGRAM		ENROLLED (✓) STATUS <input type="checkbox"/> Full time <input type="checkbox"/> Half time <input type="checkbox"/> Other (specify):		UNITS/HOURS PER WEEK		WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO		
							EXPECTED DATE OF GRADUATION				
CA FS B. Complete below for anyone enrolled in college or attending a similar educational institution.						Expenses Verified:		<input type="checkbox"/> YES <input type="checkbox"/> NO			
NAME		TERM (✓) CHECK STATUS <input type="checkbox"/> Semester <input type="checkbox"/> Year <input type="checkbox"/> Quarter		TUITION/FEES PER TERM \$		BOOKS, EQUIPMENT, ETC., PER TERM \$		Date Verified:			
MILES ROUND TRIP PER DAY TO SCHOOL/CHILD CARE		DAYS ATTENDING PER WEEK			TRANSPORTATION USED						
TRANSPORTATION COST PER WEEK \$		AMOUNT PAID PER WEEK BY CAR POOL MEMBERS \$			PUBLIC TRANSPORTATION (BUS, ETC.) PER DAY \$				Financial Aid: <input type="checkbox"/> YES <input type="checkbox"/> NO		
									<input type="checkbox"/> MC 210 S-E		
CA 18 A. Is anyone under age 20 and pregnant or a parent? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Referred to:					
NAME		AGE		CHECK (✓) STATUS <input type="checkbox"/> Pregnant <input type="checkbox"/> Teen Parent				<input type="checkbox"/> Cal-Learn			
SCHOOL STATUS, CHECK (✓) <input type="checkbox"/> Has a High School Diploma <input type="checkbox"/> Has a GED <input type="checkbox"/> Not Attending School Regularly (explain): <input type="checkbox"/> Currently Attending School Regularly <input type="checkbox"/> Other (explain):								<input type="checkbox"/> CW 25			
B. Has anyone received a cash bonus or penalty, or help with child care, transportation, etc. from the Cal-Learn Program? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:								<input type="checkbox"/> CW 25A			
NAME		WHERE (COUNTY)		DATE(S) RECEIVED				<input type="checkbox"/> Referred to Welfare-to-Work			
CA FS 19 Is anyone on strike? <input type="checkbox"/> YES <input type="checkbox"/> NO If "YES", complete below:						Striker Regs Apply:					
NAME OF STRIKER			NAME AND ADDRESS OF EMPLOYER/TRAINING PROGRAM					<input type="checkbox"/> CA <input type="checkbox"/> FS			
NAME OF UNION											
DATE WENT ON STRIKE			MONTHLY INCOME (BEFORE DEDUCTIONS) EARNED FROM THIS JOB BEFORE THE STRIKE \$								

Employment History

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CA FS **(25)** Has any parent living in the home worked or been in training in the past 24 months? ☐ YES ☐ NO

If "YES", complete below:

- Include all work done in and outside the United States (U.S.).
- Include work done in exchange for something besides money, such as rent, food, utilities or **anything else**.
- Begin with each person's most recent job or training.

COUNTY USE ONLY

PE/UIB Requirements
Earnings from month prior to month of application

App Date: _____

Earnings from _____ to _____

MO/YR (25) A (25) B

\$ \$

A. NAME IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO

IF "YES", LIST TRIBE: _____

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

B. NAME IS HE/SHE A NATIVE AMERICAN? ☐ YES ☐ NO

IF "YES", LIST TRIBE: _____

Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid	Name and Address of Employer or Training Program (✓) Check, If Work or Training	When Employed MO DAY YR From To	Amount Paid
1. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	4. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	5. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	6. <input type="checkbox"/> Work <input type="checkbox"/> Training	From To	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

FS **(26)** Are all Food Stamp household members citizens of the United States (U.S.)? ☐ YES ☐ NO

If "NO", complete below for each Food Stamp household member who is **not a citizen of the U.S.**

Name of each noncitizen	A. How many years total has this person, their spouse, and/or their parents (before this person was 18 years old) lived in the U.S.?	B. While living in the U.S., in how many of the years reported in Column A did this person, their spouse, and/or their parents (before this person was 18 years old) earn money by working in the U.S.?	C. While living outside the U.S., how many total years did this person, their spouse, and/or their parents (before this person was 18 years old) work in the U.S.?
1.			
2.			
3.			
4.			

TOTAL \$ \$

(25) A B

Tribal JOBS Referral

UIB Verif(s) on file

Must apply for UIB

CA FS MC **(27)** Has anyone been in the U.S. military service or the spouse, parent, or child of a person who has been in the military service? ☐ YES ☐ NO

If "YES", complete below:

NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE
NAME	U.S. CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO	(✓) STATUS <input type="checkbox"/> ACTIVE DUTY MILITARY/VETERAN <input type="checkbox"/> SPOUSE, PARENT OR CHILD OF ACTIVE DUTY MILITARY/VETERAN	HONORABLE DISCHARGE <input type="checkbox"/> YES <input type="checkbox"/> NO	BRANCH OF SERVICE	DATE OF SERVICE

Currently Receiving/Got/ or UIB eligible in last 12 months

UIB Ineligible Reason:

(26) FS: ☐ 40 Quarters Verif.

(27)

☐ CW 5

FS: Noncitizen's Honorable Discharge Verif.

☐ YES ☐ NO

COUNTY USE ONLY

PRINCIPAL EARNER (PE) *	DATE OF APPLICATION	QUARTER OF APPLICATION

*Principal Earner — the parent who earned the most income in the last 24 months prior to the month of application.

CA (28) A. Does anyone, including children, get or expect to get money from any source listed below? Check (✓) "YES" or "NO" for each item.							COUNTY USE ONLY		
Work Study, JTPA, Welfare-to-Work, or other program Other training allowance Educational grants, loans and scholarships CalWORKs/Cash aid from another state Refugee (RCA) Assistance Cash Assistance Program for Immigrants (CAPI) GA/GR (General Assistance/Relief) Workers Compensation Child/spousal support or money for medical bills or premiums Strike benefits Loans, gifts, contributions Legal or insurance settlements/ court actions pending Sales of notes, contracts, trust deeds, promissary notes Military allotment or pension	YES 	NO 	VA (Veterans) educational related income VA Aid & Attendance Social Security disability or supplemental security income/state supplementary payment (SSI/SSP) VA disability Railroad disability Other disability income from a federal, state, or local governmental agency Other non-government disability or sick leave Social Security retirement or survivors Railroad retirement Other retirement income from a federal, state, or local governmental agency Other non-government retirement income Per capita payments Winnings (gambling/lottery/bingo, prizes, etc.) Other (Explain)	YES 	NO 	<input type="checkbox"/> Casualty Unit Notified <input type="checkbox"/> CWC 6041 <input type="checkbox"/> DHS 6155 <input type="checkbox"/> Verif(s) on File Explain Anticip. Income Workers Comp: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent			
If "YES", complete below:						(✓) if exempt			
NAME	SOURCE	(AMOUNT RECEIVED BEFORE DEDUCTIONS)	WHEN	HOW OFTEN		CA	FS	MC	
		\$							
		\$							
CA B. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise?									
If "YES", complete below:									
NAME	WHAT	AMOUNT \$	WHEN						
CA (29) Does anyone get housing or rent, utilities, food or clothing free or in exchange for work?									
If "YES", complete below and check (✓) if free or in exchange for work:									
ITEM RECEIVED	Free	For Work	WHO RECEIVES THE ITEM	VALUE	WHO PROVIDES THE ITEM	Partial	Full	Earned	
Housing or rent				\$					
Utilities				\$					
Food				\$					
Clothing				\$					
CA (30) A. Does anyone own or is anyone buying real estate, such as land and/or buildings anywhere, including outside the U.S.?									
If "YES", complete below. Include land and/or buildings in which the title is shared.									
TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME		
	LIVE IN IT					\$	\$		
LISTED FOR SALE	RENTAL PROPERTY								
<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN):								
TYPE (LAND, CONDO, APARTMENT, HOUSE)	HOW DO YOU USE THIS PROPERTY? CHECK (✓)	YES	NO	OWNER(S)	ADDRESS OR LOCATION	AMOUNT OWED	RENTAL INCOME		
	LIVE IN IT					\$	\$		
LISTED FOR SALE	RENTAL PROPERTY								
<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER (EXPLAIN):								
CA B. Does anyone own a house that is not lived in now that he/she hopes to return to someday?									
If "YES", complete below:									
OWNER OF PROPERTY		PROPERTY ADDRESS			EXPECTED DATE OF RETURN (IF KNOWN)				
						Home Exempt <input type="checkbox"/> YES <input type="checkbox"/> NO Other Real Property Market Value \$ _____ Amount Owed \$ _____ Net Value \$ _____ Lien Applicable <input type="checkbox"/> YES <input type="checkbox"/> NO Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO			
						Home Exempt <input type="checkbox"/> YES <input type="checkbox"/> NO Other Real Property Market Value \$ _____ Amount Owed \$ _____ Net Value \$ _____ Lien Applicable <input type="checkbox"/> YES <input type="checkbox"/> NO Listed for sale <input type="checkbox"/> YES <input type="checkbox"/> NO			
						Total countable property: Page 7 (List totals on page 9) CA \$ _____ FS \$ _____ MC \$ _____			

CA
FS
MC**31) A. Does anyone, including children, have any of the following personal or business-related resources?** Check (✓) each item either "YES" or "NO".

Include all resources owned, used, controlled, shared or held jointly with any person(s) (even for convenience only). The county will determine whether or not these resources count.

	YES	NO		YES	NO
Cash (on hand or elsewhere)			Trust funds (whether or not available)		
Uncashed checks (on hand or elsewhere)			Notes, mortgages, deeds of trust, contracts of sale, etc.		
Savings accounts - children's and adult's			IRA or Keogh plans, etc.		
Checking accounts - whether or not they are used			Retirement funds which are available if you stop work (such as PERS, etc.)		
Credit union accounts			Employee deferred compensation plans		
Stocks, bonds, certificates of deposit, money market accounts, etc.			Life insurance or annuity		
Oil, mining, or mineral rights			Life estate interest in any property		
Burial trusts or contracts, insurance, designated burial funds/money for cemetery plots, caskets, or other burial items			Long term care insurance		
Income tax refund			EBT cash balance from a previous month		
			Other (explain)		

IF "YES", COMPLETE BELOW:

RESOURCE	BUSINESS-RELATED	OWNER	ACCOUNT/POLICY NO.	NAME AND ADDRESS OF BANK, ETC.	CURRENT VALUE
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO				\$

CA FS MC B. Does anyone get or expect to get money from any of the above resources, such as interest, dividends, etc.? ☐ YES ☐ NO

If "YES", complete below:

NAME	SOURCE OF MONEY	AMOUNT	HOW OFTEN	BUSINESS-RELATED
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO
		\$		<input type="checkbox"/> YES <input type="checkbox"/> NO

MC 32) Are there any liens recorded or did you sign a security agreement with a doctor, clinic, or hospital against any property owned by you or any family member that is used as security for health care services? ☐ YES ☐ NO

If "YES", complete below:

LIEN OR SECURED AMOUNT	TYPE AND LOCATION OF PROPERTY	DATE AND TYPE OF MEDICAL CARE RECEIVED/TO BE RECEIVED	NAME OF PROVIDER
\$			
\$			

MC 33) A. Does anyone own any personal property, such as: ☐ YES ☐ NO

- Non-motorboats, camper shells, non-motor trailers.
- Guns; tools; or sporting equipment, etc.
- Pets or livestock for personal use.
- Jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.).

If "YES", complete below: Do not include wedding and engagement rings or heirlooms. List jewelry worth more than \$100 and household goods or personal items worth more than \$500 per item.

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

MC B. Does anyone have any business property, including tools, inventory and materials, business equipment, livestock, etc.? ☐ YES ☐ NO

Include any property that is shared or held jointly with any other person(s). If "YES", complete below:

ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED	ITEM	LISTED FOR SALE	PURCHASE PRICE OR CURRENT VALUE	AMOUNT OWED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$

COUNTY USE ONLY

☐ Trust Fund/Not Court Ordered

☐ Court Petitioned Date _____

☐ Resource Verified: Explain how: _____

Total Value = \$ _____

☐ Burial Reserve or Trust (MCO) Amount Owed \$ _____

☐ Revocable

☐ Irrevocable

☐ Designated Fund and Current Value \$ _____

☐ CA Restricted Account

Check (✓) if exempt

CA	FS	MC

Verified: ☐ YES ☐ NOLien Applicable: ☐ YES ☐ NOSecurity Agreement: ☐ YES ☐ NOMC 174 completed and sent: ☐ YES ☐ NO

- ☐ Owned Jointly
- ☐ Owned Separately

☐ Personal Property \$500 + for Pickle Program☐ Insignificant Value for 1931(b)☐ Listed for sale (Specify): _____

Total Countable Property: Page 8 (List totals on Page 9)

CA \$ _____

FS \$ _____

MC \$ _____

☐ Listed for sale (Specify): _____

CA FS MC	(34)	Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts, money from a legal or accident insurance settlement, or anything else? (List any property sold or traded within the last 12 months for cash aid, 3 months for food stamps, and within the last 2 1/2 years (30 months) for Medi-Cal). If "YES", explain what and when:	<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY																				
				Transfer of Assets: <input type="checkbox"/> CA in last 12 months <input type="checkbox"/> FS in last 3 months <input type="checkbox"/> Medi-Cal in last 30 months LTC ONLY <input type="checkbox"/> Adequate Consideration <input type="checkbox"/> Spenddown Total Nonexempt Property \$																				
CA FS MC	(35)	Does anyone own, have the use of or have their name on the registration of any motor vehicle, such as: automobile, motorcycle, snowmobile, recreational vehicle, motorboat, etc., even if not running? If "YES", complete below. Look at your registration to get facts for each vehicle:		<input type="checkbox"/> YES <input type="checkbox"/> NO																				
		VEHICLE (1)	VEHICLE (2)	VEHICLE (3)																				
OWNER OF VEHICLE																								
NAME OF PERSON WHO USES VEHICLE																								
YEAR/MAKE/MODEL																								
LICENSE NUMBER																								
ESTIMATED VALUE		\$	\$	\$																				
BALANCE OWED		\$	\$	\$																				
LICENSED		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																				
LEASED		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																				
HOW DO YOU USE THE VEHICLE? Check (✓) each item "YES" OR "NO."		YES	NO	YES																				
As a Home																								
To go to work or training or for job search																								
For self-employment, self-support, or business use																								
Needed for disabled household member																								
To get household's fuel or water																								
For recreational use only																								
COUNTY USE ONLY - VEHICLES																								
CASH AID/FOOD STAMPS		VEHICLE (1)	VEHICLE (2)	VEHICLE (3)																				
(A) Is vehicle a home, income producing, primary transportation to get fuel/water, or used for a disabled household member? (63-501.521)		<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).	<input type="checkbox"/> YES <input type="checkbox"/> NO (Exclude) Go to (B).																				
(B) (1) Equity: exempt one vehicle, regardless of use. (63-501.523) [If "YES", go to (C). If "NO", go to (B)(2).]		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO																				
(2) Is other vehicle(s) used for job search, employment or training?		<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Go to (C) and Use Excess Value. Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Go to (C) and (D). Use Greater Value.	<input type="checkbox"/> YES <input type="checkbox"/> NO Go to (C). Go to (C) and (D). Use Greater Value.																				
MEDI-CAL																								
		(1)	(2)	(3)																				
DMV/YR/Class Code				\$																				
Vehicle Market Value		\$	\$	\$																				
Less Encumbrances		\$	\$	\$																				
Net Value		\$	\$	\$																				
Exempt		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N																				
Pickle Program (Ref. Sec. 9 in Pickle Handbook):		(1)	(2)	(3)																				
Is vehicle used:		Exempt	Yes No	Yes No																				
As a home																								
For self-employment																								
To Go to Work or Medical Appointment																								
		TOTALS: VEHICLE CA/FS Excess Value \$ Equity Value \$																						
		Grand Total Countable Property (List totals from pages 7, 8, and 9) <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%;">Page</td> <td style="width:10%;">CA</td> <td style="width:10%;">FS</td> <td style="width:10%;">MC</td> </tr> <tr> <td>(9)</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> <tr> <td>(8)</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> <tr> <td>(7)</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> <tr> <td>Total</td> <td>\$</td> <td>\$</td> <td>\$</td> </tr> </table>			Page	CA	FS	MC	(9)	\$	\$	\$	(8)	\$	\$	\$	(7)	\$	\$	\$	Total	\$	\$	\$
Page	CA	FS	MC																					
(9)	\$	\$	\$																					
(8)	\$	\$	\$																					
(7)	\$	\$	\$																					
Total	\$	\$	\$																					

CA FS (36) A. Does anyone have any housing costs? ☐ YES ☐ NO
If "YES", complete below:

HOUSING COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Rent	\$	\$	\$	
House (mortgage) payment	\$	\$	\$	
Property taxes (if not in house payment)	\$	\$	\$	
Insurance (if not in house payment)	\$	\$	\$	
Other (explain)	\$	\$	\$	

CA FS B. Does anyone else pay all or part of these housing costs? Include a relative or friend not living in the home, any rental assistance programs, such as HUD, Section 8, etc. If "YES", complete below: ☐ YES ☐ NO

TYPE OF HOUSING COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	
		\$	

COUNTY USE ONLYHousing verified: ☐ YES ☐ NO

Total housing: \$ _____

Shared housing: ☐ YES ☐ NO

FS (37) A. Does anyone have any utility costs? ☐ YES ☐ NO
If "YES", complete below:

UTILITY COSTS	TOTAL COST	HOW MUCH YOU PAY	HOW MUCH OTHER FAMILY/ HOUSEHOLD MEMBERS PAY	HOW OFTEN BILLED
Gas or other fuel	\$	\$	\$	
Electricity or other fuel	\$	\$	\$	
Is the gas or electricity or other fuel used to heat or cool your house?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Water	\$	\$	\$	
Sewer	\$	\$	\$	
Garbage or trash	\$	\$	\$	
Telephone (basic rate for one phone plus tax)	\$	\$	\$	
Installation of utilities	\$	\$	\$	
Other (explain)	\$	\$	\$	

Utilities verified: ☐ YES ☐ NOMetered: ☐ YES ☐ NO

Client elects

☐ Actual

If Actual, Total Utilities

\$ _____

☐ SUA

SUA prorated:

☐ YES ☐ NO

FS B. Does anyone else pay all or part of these utility costs? Include a relative/friend not living in the home, Low Income Energy Assistance, etc. If "YES", complete below: ☐ YES ☐ NO

TYPE OF UTILITY COST	NAME OF PERSON WHO PAYS	HOW MUCH EACH PAYS	HOW OFTEN BILLED
		\$	
		\$	

FS (38) You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:

NAME OF AUTHORIZED REPRESENTATIVE	ADDRESS	PHONE
		()

☐ F.S. I.D. Issued

CA MC	39 Did anyone get medical/pregnancy treatment this month or in the three months before this month? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">NAME OF PERSON RECEIVING CARE</th> <th style="width: 20%;">MONTHS OF CARE</th> <th colspan="2" style="width: 20%;">PAYMENTS MADE FOR CARE</th> <th colspan="2" style="width: 30%;">DO YOU WANT MEDI-CAL FOR THOSE MONTHS?</th> </tr> <tr> <th></th> <th></th> <th>YES</th> <th>NO</th> <th>YES</th> <th>NO</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS?				YES	NO	YES	NO													Retroactive Application <input type="checkbox"/> Retro Only <input type="checkbox"/> Retro and Cont. <input type="checkbox"/> MC 210A										
NAME OF PERSON RECEIVING CARE	MONTHS OF CARE	PAYMENTS MADE FOR CARE		DO YOU WANT MEDI-CAL FOR THOSE MONTHS?																																
		YES	NO	YES	NO																															
CA FS MC	40 Does anyone have MEDICARE coverage? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE referral FS: <input type="checkbox"/> DFA 285-C Gross Premium \$ _____ <input type="checkbox"/> QMB <input type="checkbox"/> SLMB/QI <input type="checkbox"/> QDWI																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 30%;">PERSON COVERED</th> <th style="width: 20%;">MEDICARE CLAIM NUMBER</th> <th colspan="4" style="text-align: center;">(✓) HOW MONTHLY PREMIUM IS PAID</th> </tr> <tr> <th></th> <th></th> <th>FOR</th> <th>DEDUCTED FROM CHECK</th> <th>OUT OF POCKET</th> <th>OTHER</th> </tr> <tr> <td rowspan="2"> </td> <td rowspan="2"> </td> <td>Part A</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Part B</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td rowspan="2"> </td> <td rowspan="2"> </td> <td>Part A</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Part B</td> <td> </td> <td> </td> <td> </td> </tr> </table>		PERSON COVERED		MEDICARE CLAIM NUMBER	(✓) HOW MONTHLY PREMIUM IS PAID						FOR	DEDUCTED FROM CHECK	OUT OF POCKET	OTHER			Part A				Part B						Part A				Part B					
PERSON COVERED	MEDICARE CLAIM NUMBER	(✓) HOW MONTHLY PREMIUM IS PAID																																		
		FOR		DEDUCTED FROM CHECK	OUT OF POCKET	OTHER																														
		Part A																																		
		Part B																																		
		Part A																																		
		Part B																																		
CA MC	41 Does anyone have health, dental, vision, hospitalization or Long Term Care insurance or health plans, such as Kaiser, Blue Cross, CHAMPUS, etc.? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	State Certified LTC Policy: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> DHS 6155 Benefits Paid Out \$ _____																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON INSURED</th> <th style="width: 15%;">EXPIRATION DATE</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 20%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> </table>		INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$																					
INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID																																
			\$																																	
			\$																																	
CA MC	42 Does anyone have any health insurance available from a parent, employer, or absent parent, which has not been applied for? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> DHS 6155																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON TO BE INSURED</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 35%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> </table>		INSURANCE COMPANY		PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID			\$				\$																							
INSURANCE COMPANY	PERSON TO BE INSURED	PREMIUM AMOUNT	HOW OFTEN PAID																																	
		\$																																		
		\$																																		
CA MC	43 Is anyone's health insurance expected to end or has it ended within the last 60 days? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> DHS 6155																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">INSURANCE COMPANY</th> <th style="width: 25%;">PERSON INSURED</th> <th style="width: 15%;">EXPIRATION DATE</th> <th style="width: 15%;">PREMIUM AMOUNT</th> <th style="width: 20%;">HOW OFTEN PAID</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td>\$</td> <td> </td> </tr> </table>		INSURANCE COMPANY		PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID				\$					\$																				
INSURANCE COMPANY	PERSON INSURED	EXPIRATION DATE	PREMIUM AMOUNT	HOW OFTEN PAID																																
			\$																																	
			\$																																	
CA MC	44 Does anyone have a disability caused by injury or accident which makes it difficult for them to work or take care of their needs? If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Third Party Liability																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">NAME OF PERSON</th> <th style="width: 30%;">TYPE OF PROBLEM</th> <th style="width: 20%;">DATE PROBLEM STARTED</th> <th style="width: 25%;">EXPECTED DATE OF RECOVERY</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>		NAME OF PERSON		TYPE OF PROBLEM	DATE PROBLEM STARTED	EXPECTED DATE OF RECOVERY																														
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CA FS	45 A. Does anyone have a medical condition(s) or situation(s) that requires any of the following? Check (✓) each item "YES" or "NO":		Verified: <input type="checkbox"/> YES <input type="checkbox"/> NO Special Need: <input type="checkbox"/> YES <input type="checkbox"/> NO Amount: \$ _____																																	
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;"> </th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> <th style="width: 30%;"> </th> <th style="width: 10%;">YES</th> <th style="width: 10%;">NO</th> </tr> <tr> <td>Special diet-prescribed by a doctor</td> <td> </td> <td> </td> <td>Very high use of utilities</td> <td> </td> <td> </td> </tr> <tr> <td>Special transportation need</td> <td> </td> <td> </td> <td>Special laundry service</td> <td> </td> <td> </td> </tr> <tr> <td>Special telephone or other equipment</td> <td> </td> <td> </td> <td>Other (specify):</td> <td> </td> <td> </td> </tr> <tr> <td>Housework (no one in the home can do it)</td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>				YES	NO		YES	NO	Special diet-prescribed by a doctor			Very high use of utilities			Special transportation need			Special laundry service			Special telephone or other equipment			Other (specify):			Housework (no one in the home can do it)									
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Special telephone or other equipment			Other (specify):																																	
Housework (no one in the home can do it)																																				
If "YES", explain:																																				
CA MC FS	B. Is there a child or disabled person in the household who needs care from another household member? If "YES", explain:		<input type="checkbox"/> YES <input type="checkbox"/> NO																																	
C. Is anyone a disabled person who is working and who has medical expenses (wheelchair, etc.), which are needed for the person to be able to work? If "YES", complete below:		<input type="checkbox"/> Receipts <input type="checkbox"/> MC 272 <input type="checkbox"/> MC 273 <input type="checkbox"/> IRWE (QMB and SGA)																																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">NAME OF PERSON</th> <th style="width: 40%;">TYPE OF EXPENSE</th> <th style="width: 35%;">AMOUNT</th> </tr> <tr> <td> </td> <td> </td> <td>\$</td> </tr> <tr> <td> </td> <td> </td> <td>\$</td> </tr> </table>		NAME OF PERSON	TYPE OF EXPENSE	AMOUNT			\$			\$	FS: <input type="checkbox"/> DFA 285-C																									
NAME OF PERSON	TYPE OF EXPENSE	AMOUNT																																		
		\$																																		
		\$																																		
CA FS	D. Is anyone getting In-Home Supportive Services (IHSS)? If "YES", who gets service? _____ How much do you pay each month? \$ _____		<input type="checkbox"/> YES <input type="checkbox"/> NO																																	

CA (46) Does the household want to apply for a special need payment for housing or essential household items lost or damaged due to sudden and unusual circumstances, such as an earthquake, fire, or flood? If "YES", explain below.	<input type="checkbox"/> YES <input type="checkbox"/> NO	COUNTY USE ONLY						
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Special Need Verified</td> <td style="width: 20%; text-align: center;">YES NO</td> </tr> <tr> <td>Eligible for Special Need</td> <td style="text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> </table> </td> </tr> </table>	Special Need Verified	YES NO	Eligible for Special Need	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> </table>		
Special Need Verified	YES NO							
Eligible for Special Need	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 20px;"></td> <td style="width: 50%; height: 20px;"></td> </tr> </table>							
CA (47) Is any member of the household avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of probation or parole? If "YES", give name of the person:	<input type="checkbox"/> YES <input type="checkbox"/> NO							
CA (48) Has any member of the household been <u>convicted</u> of a drug-related felony for possession, use, or distribution of a controlled substance(s)? Give facts for cash aid, for convictions on or after 1/1/98; and for food stamps, for crimes and convictions after 8/22/96. If "YES", complete below:	<input type="checkbox"/> YES <input type="checkbox"/> NO							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">NAME OF PERSON CONVICTED</td> <td style="width: 33%;">DATE CONVICTED</td> <td style="width: 33%;">DATE CRIME COMMITTED</td> </tr> <tr> <td style="height: 20px;"></td> <td></td> <td></td> </tr> </table>	NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED					
NAME OF PERSON CONVICTED	DATE CONVICTED	DATE CRIME COMMITTED						
CA (49) The following services are available. Your answers to these questions will not affect your eligibility. Check (✓) each item "YES" or "NO."	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CHDP Brochure and Explanation Given Date: _____						
A. Regular check-ups to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CHDP Referral						
• Do you want more information about CHDP Services?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Social Services Referral (MCO)						
• Do you want CHDP medical services?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
• Do you want CHDP dental services?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
• Do you need help making appointments or with transportation to CHDP services?	<input type="checkbox"/> YES <input type="checkbox"/> NO							
B. Do you want more information about immunization services?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Referred for Immuniz.						
C. If you are pregnant, you can get help finding a doctor, getting healthy foods, and other help. Do you want to talk to someone about this help?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Pregnant <input type="checkbox"/> Parent or Guardian of child under 5						
D. Are you breastfeeding a child? If "YES", have you given birth within the last 12 months? If you checked "YES" to (49) C or D, you may be eligible for services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum <input type="checkbox"/> WIC referral						
E. Do you or any family member want free or low-cost family planning services to help plan how to prevent unplanned pregnancies and/or have the next child? If "YES", call your health care plan or regular doctor. Or, for facts and the location of confidential family planning clinics, call toll-free 1-800-942-1054.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Family Planning Information Given <input type="checkbox"/> Referred Date:						

CERTIFICATION

I understand that:

- Any facts I gave, including benefit and income facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.
- All facts, including benefit and income facts, I gave may be reviewed and checked out by county, state, and federal personnel, and that if I gave wrong facts, my cash aid, food stamps, and Medi-Cal may be denied or stopped.
- My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.
- The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am not (a) a lawful permanent resident noncitizen (LPR), (b) an amnesty alien with a valid and current I-688, or (c) a noncitizen permanently residing in the United States under color of law (PRUCOL), the county will not send facts to the INS.
- I must apply for and keep any available health coverage if no cost is involved; if I do not my Medi-Cal will be denied or stopped.
- I or other family members will be required to repay any cash aid I should not have received.
- The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a noncitizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.
- Any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.
- Anyone who has committed and been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) since August 22, 1996, cannot get food stamps or if convicted on or after January 1, 1998, cannot get cash aid.
- For cash aid and food stamps, the county will require that I and certain household members be fingerprint and photo imaged. My benefits may be denied or stopped if I do not cooperate.

I also understand that:

I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

For cash aid:

- If I on purpose do not follow cash aid rules, I may be fined up to \$10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:
 - For not reporting all facts or for giving wrong facts: 6 months for the first offense, 12 months for the second, or forever for the third; and for Refugee Cash Assistance, 3 months for the first and 6 months for any later offense.
 - For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
 - For conviction of felony thefts to get aid: 2 years for theft of amounts under \$2000; 5 years for amounts of \$2000 through \$4999.99; and forever for amounts of \$5000 or more.
 - For giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than \$10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing: forever.

For food stamps:

- If on purpose I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to \$250,000 and/or sent to jail/prison for 20 years.
- If I am found guilty in any court of law because:
 - I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
 - I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
 - I traded or sold food stamps that were worth \$500 or more, my food stamps can be stopped forever.
 - I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this statement of facts is true, correct, and complete.

SIGNATURE (PARENT OR CARETAKER RELATIVE, MEDI-CAL APPLICANT, ADULT FOOD STAMP HOUSEHOLD MEMBER OR FOOD STAMP AUTHORIZED REPRESENTATIVE)		DATE	
SIGNATURE (OTHER PARENT LIVING IN THE HOME, IF APPLYING FOR CASH AID)	DATE	SIGNATURE OF WITNESS TO MARK, INTERPRETER OR PERSON ACTING FOR APPLICANT/BENEFICIARY	DATE

COUNTY USE ONLY																				
ELIGIBILITY FACTORS REVIEWED						ELIGIBILITY FACTORS REVIEWED						FOOD STAMP TESTS								
		CA		FS		MC				CA		FS		MC			YES	NO	NA	
		YES	NO	YES	NO	YES	NO			YES	NO	YES	NO	YES	NO					
Residency								Property/Resources—Within limits									Categorically Eligible			
Deprivation																	Gross Income Test Household Size			
Age								Work participation									Gross Monthly Income \$			
Immunizations								FSET									Gross Income Eligible			
Citizen/Eligible noncitizen								ABAWDs									Separate HH Income Test Household Size			
School enrollment								CFAP									Gross Monthly Income \$			
Pregnancy verif./ WIC Referral								Sponsored noncitizen Federal participation established (If "NO", explain)									Eligible for Separate HH Status			
SSN																	Aged/Disabled			
Income—Applicant/Recipient test(s)								Referred for Health Care Options (HCO) Presentation									DFA 285-C			
SFIS																				
TANF Time Limits																				
CalWORKs Time Limits																				

COMMENTS

AU Size:	Non-AU Size:	AU/MFBU Size:	FS:	HH Size:
<input type="checkbox"/> INELIGIBLE (REASON)			<input type="checkbox"/> INELIGIBLE (REASON)	
<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> REDETERMINATION		<input type="checkbox"/> DIVERSION <input type="checkbox"/> EXEMPT MAP	<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> RECERTIFICATION	
ELIGIBILITY CONDITIONS MET (DATE):		EFFECTIVE DATE		
WORKER'S SIGNATURE		DATE	WORKER'S SIGNATURE	
SUPERVISOR'S SIGNATURE (COUNTY OPTION)		DATE	SUPERVISOR'S SIGNATURE (COUNTY OPTION)	